MARYLAND JUDICIARY

FAMILY AND MEDICAL LEAVE
RETURN TO WORK MEDICAL CERTIFICATION FORM

Please type or print. Absences of three or more days **require** a return to work certificate.

PART I: EMPLOYEE INFORMATION

Name: _____ Job Title: _____

Social Security No.: _____ Work Phone Number: _____

Date Leave Commenced: _____ Department/Work Location: _____

Return to Work Date: _____

Please type or print

PART II: TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

Provider's Name: _____

Provider's Address: _____

_____

Provider's Phone Number: _____

I certify that on _____(date), I examined _____ (name of employee), and on the basis of my examination, this employee is ready to return to work and is able to perform the functions of his/her position.

_____ _____

Provider's Signature Date

PART III: TO BE COMPLETED BY EMPLOYER (Employer remarks)

This form should be delivered or mailed to: _____

_____

_____

_____

RESET FORM